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ABSTRACT

This paper addresses the shortage of physicians providing medical services to rural communities in Queensland, Australia. Queensland is the fastest growing Australian state, but it has the lowest ratio of total doctors to population. Data indicate there may be twice as many patients per rural doctor compared with the city, which represents a considerable gap in equity and access for the rural sector. Recently, there have been efforts to address physician shortages in rural areas, including the development of rural medical training programs and the establishment of posts to increase training opportunities for rural practitioners. However, the problems associated with retention of rural physicians have not been adequately addressed. Factors affecting retention of rural physicians include professional factors, social and other variables affecting the physician's family, and community influences. Research on retention of physicians in rural areas should focus on such areas as maintaining the professional interest of physicians in rural practice, the importance of an appropriate workload, employment opportunities for spouses, availability of quality education for physician's children, the effect of petty jealousy toward the physician's income and status, availability of quality housing, proper time-off from work, and the influence of community attitudes toward its health needs. Contains 29 references. (LP)

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HOW TO CATCH AND KEEP A RURAL DOCTOR

Digby Hoyal — Australia

1. THE PROBLEM

A torrent of discussion has taken place in the last five years on the problem of providing medical services to the rural communities of Queensland.

It appears that the difficulties are no new thing. A plea from Dr M Patkin[1] appeared in 1968 entitled "The rural doctor problem."

A flurry of activity took place in the late seventies culminating in the Conference, "Country Towns, Country Doctors" in1979[2] perhaps following a paper in 1978 by Cõlditz GA and Elliott CJP on Queensland's Rural Practitioners.[3]

At that time there was a general shortage of doctors in Australia although it was most noticeable in the provincial cities and country areas.

In spite of major increases in doctors numbers and proportions since then the doctors seem to have joined the rest of the population in migrating to the cities.

The problem has thus become acute. In spite of this it remains largely unquantified and the indices that have been applied remain relatively blunt statistical weapons. Figures vary greatly but the following are probably among the more representative.

Queensland, as the fastest growing state, probably has the lowest ratio of total doctors to population of any Australian state,[4] certainly below the index figure of 200.

The Commonwealth Department of Health, Statistical services section distributed 1989 census figures by the Remote and Rural Areas Classification (RARA) to arrive at ratios of one GP doctor to 641 patients in the metropolitan area, but 1078 in Rural major, 1458 in Rural Other, 1408 in Remote Major and 1229 in Remote other.[5]

A slightly lower number of services is recorded annually by Medicare for rural as opposed to city GPs and this is consistent with US figures of 4.5 physician contacts for rural and 5.3 for urban patients annually[6] but this must be heavily outweighed by range and complexity of services including inpatient services provided by rural GPs.

RDAQ has on its Database 401 rural doctors which includes all those it can identify in public and private practice. With a rural (RARA 3-6) population of a shade below 1M the practical ratio of rural patients to doctors approaches 2400 once the provincial cities and satellite areas are excluded.

There may be as many as twice as many patients per rural doctor compared with the city. This represents a considerable gap in equity and access for the rural sector whose labour supplies all the wealth of this State, through Coal, Wheat, Cattle, Cotton, Bauxite, Silver- lead, Wool and all the other primary products that make Queensland the best heeled state in Australia. Certainly the contribution of the BMW drivers in Brisbane is not huge!

To reach parity a further 112 GPs or so would be required now and the situation is deteriorating in spite of recent conscious efforts to address it.

2. RECRUITMENT TRAINING AND RETENTION

The fundamental truth was iterated by Max Kamien in the West Australian report of 1987 "Rural practice is ultimately a matter of establishing doctors' families in the country, since rural practice is a family concern"[8]

Trans 1 "Recruitment, Training and Retention

Suggested areas for study are legion but the total volume of published studies is piteously small. Much more is apparently in progress and yet more requires to be initiated. Here are a few strategies in current view in the Queensland situation.

Trans 2 Training,

Training and educational considerations have been well addressed and processes are operative to meet the needs of the future through the FRM, The RACGP Training Programme, and the four Rural Health Training Units, together with the fortification of the University of Queensland General Practice and Rural Medicine components. I have left this subject to the experts.

Trans 3 Recruitment

Recruitment is also being addressed, though with less enthusiasm since it is outside the usual practice of educational institutions to apply affirmative techniques and due also to some suspicion of the figures. Certainly the rural origin theory of Rabinowitz[9] seems well supported by Practice Intentions expressed in the South Australian Study of 1992[10]

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Also 1993 "Workforce Characteristics of Medical Practitioners in Queensland 1991"[11] seems to refute Biggs and supports the need to ensure that pupils from country schools have equitable access to Medical School places.

The Rural Doctors Association of Queensland supports programmes aimed at proselytizing rural pupils as well as those offering support to Medical Students through Rural Clubs, Mentors, Pastoral workers and assistance with matched clinical attachments at all levels in rural practices.

Due to the impressive commitment of individuals, institutions and governments, many programmes are addressing Recruitment and Training. The Transfusion is starting to flow.

3 RETENTION

Unfortunately the Haemorrhage has not yet been stemmed. The saddest feature of rural medicine is the continuous loss of doctors from the Bush.

Various studies have pointed out the positive features of rural lifestyle and interesting rewarding work. It has been assumed, reasonably that most rural doctors would stay in the country unless the summation of negative features caused them to leave.

If the literature on recruitment and training is inadequate, that dealing with the retention of rural doctors is piteous. Yet the whole effectiveness of Recruitment and Training is entirely dependent on maintaining Rural GPs in situ for at least the present modal duration.

Also small increases in retention make huge improvements to workforce statistics.

Wise et al 1992[12], note that 32% of doctors surveyed expected to leave within 3 years, 44% in six years and 77%indicated they would choose a non-rural position if they moved.

Quantitative statistics based on whole populations are useful , but, if we are to find ways to increase retention rates, we must use qualitative methods that identify the problems in each case, and help to point to solutions. Each doctor leaves for reasons that compel him to make a major move of household and work probably to a slightly less well remunerated situation. We need to seek the proximate causes of such serious decisions in each case.

The Medicare statistics approach taken by Adhikari, Calcino and Dickinson[14] offers a method of looking overall at the workforce situation but they themselves point out the weakness of using broad figures and the need to follow cohorts of entrants into rural practice as used by Pathman[15].

Let us examine what we presently believe are the influences.

First the *professional factors affecting the Doctor, second the social and other factors affecting the medical family and third the community influences and predilections that may be operative.*

Trans 4 Retention. Professional

A. THE DOCTOR- PROFESSIONAL FACTORS

i. THE INTEREST

The appeal of rural practice in its technical breadth and the close personal relationship between the doctor the patient and the ancillary staff.. This is highly dependent upon a well equipped local hospital and strong loyalty and support of the doctor by the hospital and community health staff. John Humphreys[16] has demonstrated the pivotal importance to rural patients of the local doctor and the local hospital. This may not be gratifying to other professionals and services but its significance must be accepted. Modern pushes by sundry groups to talk up their importance in the health field is understandable. However it is the patient's perception that must receive most respect. It is important that those who supervise rural hospitals ensure that the whole district supports the hospital and the hospital stands firmly behind its doctor or doctors. It is those doctors who work exceptional hours and accept enormous emotional and professional loadings. For most of Queensland it is unnecessary to stress this point but as one who left a country town due to jealousy and disloyalty by competitive staff, I feel that it must be pointed out that a few towns who continuously lose better than adequate doctors cognizance must be taken of the need for that loyalty and support, and Health Authorities must back their MSRPPS and Superintendents.

Likewise the interest of the work depends on the ability of the doctor to exercise the skills which have been laboriously acquired so as to benefit rural patients. The role delineation of the country hospital must be seen as a planning tool aimed at increasing the range and quality of procedural services, and not as a weapon to achieve scale savings based on marginal costings of procedures.

It has been well shown that in Obstetrics[17] and Anaesthetics,[18], two of the most demanding procedural areas, that the services of rural GPs carry no higher morbidity than those in tertiary referral centres. Certainly the patient demand for such services seems strong though we have yet no researched evidence to support that.

Administrators must consider not the marginal costs of procedures but the total community cost. This includes the cost of maintaining a hospital presence at all in a rural centre together with the transport and follow up costs to health services and patients as well as the loss of productive work time and cost of child care etc by the patient and family. Early figures from the Flying Obstetrical and Gynaecology services indicate that the costs of obgyn procedures carried out at rural hospitals by the team are considerably less than those pertaining to regional hospitals.[19]

Flexibility is also vital. Rigid adherence to state and federal funded programmes is inappropriate in the small rural centre where respite, nursing home and acute beds are needed in variable mixes varying with time. The move to enable "Cashing out of hospitals or districts is recommended in NHS Strategy Background Paper 11[20] and it is hoped that multi-functional centres will be managed flexibly and quite soon.

The principal that it is necessary to perform planned procedures(eg. Caesarean section) in the clear light of day with all staff and systems in order to be ready for emergencies must be appreciated. Some "button counters" seem to miss the need for practice in order to ensure staff and equipment remain honed.

Unsavoury competition between "Public" and "Private" considerations presses heavily on many rural doctors. *The difference is artificial and never benefits the patient.* RDAQ is pressing for access to public patients by all accredited rural doctors on a Fee For Service basis to ensure that the skills of many are not lost to public patients since with low participation in Hospital insurance Schemes most procedures in the bush tend to be Public. Often a procedure has to be carried out by a less well trained public doctor as the most qualified is "Private". Further activity is needed to address this which also bears on the willingness of Private GPs to offer relief to the local hospital doctor.

The medico-legal position of proceduralists invites consideration. The Western Australian experience of GPs ceasing Obstetrics is becoming mirrored in Queensland. Some doctors have announced retirement from obstetrics and rural trainees are wondering whether it will be economic for them to accept small obstetric loads for financial and litigous reasons. The Federal Health Department cannot afford to wait for the Tito Committee. Action is needed now .

Queensland Health has recently embarked on a programme to encourage specialists to set up in rural centres as needed. Such specialist support is excellent and will relieve GPs of some strain. However placements must be handled sensitively to avoid competition for procedures that the GPs customarily perform in rural locations.

Retention clearly depends on maintaining professional interest. How can we do it better?

3

ii. THE WORKLOAD

None of you would get into a plane that was about to be piloted by someone who had flown continuously for twenty four hours a day

for the previous twelve weeks. It is surprising that patients entrust their appendix or delivery to a doctor who works such hours. The 1992 South Australian Study records Pressure of work as the second highest factor likely to influence rural GPs to leave.[10]

The right to relief established by Medical Superintendents with Right of Private Practice (MSRPPs) in 1988 has improved the situation but the foremost request by GPs for services from RDAQ and Divisions is for Locums.

The RIP scheme will help but a very flexible and opportunist policy is required to pick up on all opportunities to relieve the excessive on-call time and recall load of rural doctors. The Divisions are working on this and expect to spend $480,000 this year on a range of schemes to employ locums in Queensland.

Quantitative study of the workloads of Rural GPs is lacking. Work in progress by Sondergeld S. on the work load of and use of time by Medical Superintendents with Rights of Private Practice in Queensland should assist in preparing cases for industrial review of workloads.[11]

More research is needed on the work of the Private GPs and possibilities of better sharing of on-call and recall duties.

A concept that calls for consideration is that espoused by the Ontario Medical Association-1993 Interim Agreement on Economic Arrangements,[12] which agrees that "The Government will attempt to provide for contracts such that where possible at least two physicians are available for any one designated community and adjacent areas or communities". Research is needed into the acceptability of such a scheme to rural communities that have traditionally demanded their own doctor and into the industrial ramifications to Government.

Adequate support staff are essential to mitigate the effects of long hours of work. Walton et al 1990 in New Zealand[13] reported that rural GPs consistently had fewer staff than urban practices. It would be interesting to know if the same applied in Queensland.

B. THE DOCTOR'S FAMILY.

[Trans 5 The Family and community]

i. SPOUSE"S EMPLOYMENT

To return to Max Kamien's "bon mot"[*], the presence of a rural doctor implies settlement by the doctor's family. The employment of the partners,(Spouses, Wives etc) is critical.

The qualitative studies of the PGMEC group[14] demonstrates much frustration by spouses at inability to obtain work for which they are trained and reveals antagagonism by rural communities to doctors wives taking paid work, especially in hospitals. Given the bias of medical students for teaming up with "other doctors, nurses and barmaids as these are the only women they ever meet" this is a source of family stress that calls for both research and positive action.

Health authorities could create job sharing or part time positions to keep doctors spouses active in their professions. This could benefit the communities and hopefully assist in retention.

Contented spouses rightly respected as vital components for retention. The enormous influence of spouses on the career paths of medical husbands has been demonstrated by Skipper and Edwards,[15]. Some additional perceptions of the pivotal role of doctor's wives in local communities come from Lorch and Crawford, 1983[16] who noted the high community expectations placed on them and the great disadvantages due to their spouses long hours of work. These factors were regarded as negativing the social status conferred by being a doctor's spouse.

More work is needed here.

ii. EDUCATION

The desire of doctors to ensure that their children receive education consistent with hopes of professional careers is at odds with the lower expectations of many country secondary schools in spite of very considerable work by rural school staff to raise academic standards. Certainly Queensland Health figures for medical school entry confirm the bias against non-Metropolitan and State school pupils for places.[17].

The South Australian Study[10] indicates that Children's Education is the most potent reason for rural GPs intention of leaving the country.

Most mining companies provide for boarding education costs for key employees. Governments are reticent to open a new field for claims by sundry professionals working in the bush. Nevertheless it almost certainly would be less expensive for them to provide such benefits than to continue to train and place new employees. Investigation of this aspect may assist the position although there will always be GP's families unwilling to surrender their children to distant boarding schools. Trends for new private schools in district centres may relieve the situation. Some research is called for into this potent predictor against retention.

Some doctor's children find themselves discriminated against in rural schools mainly because they are seen as "rich kids". This may add to weight to decisions to board.

iii. MONEY AND JEALOUSY

Many rural dwellers may have property and indeed incomes much greater than those of the local doctor. Most of these tend to live outside the townships on properties and mines etc. In a town only the shire clerk, engineer and a few traders are likely to have a level of discretionary spending power that approaches that of the doctor. Certainly the Nursing and managerial staff of local hospitals can not compete. The mature attitude to this was well expressed recently by Johnson J. Queensland Country Life[21] "Nobody minds them earning more than a fair day's pay, because they undoubtedly put in more than a fair day's work and are an important part of our community services".

Nevertheless all are not mature, and a fair amount of petty jealousy is sometimes detectable especially in communities where things are going badly , as in drought, when the doctor's income seems quarantined from the disaster affecting most others. Much tact and goodwill may be needed and it all adds to the strain on the medical family.

iv. HOUSING

Housing standards for doctors and for their locums have not received much thought. Poor housing contributes to the lack of privacy complained of frequently by spouses.[24]

Government servants in the bush have entitlements to certain standards, but GPs are not government servants. Much rural housing is poor and expensive. a few doctors have invested unrecoverable sums in order to make their lives comfortable. Most are not prepared for such financial sacrifice since such houses rarely sell for the cost of construction and the market is slow.

Local and health authorities could set standards for construction and such facilities as air-conditioning in order to encourage doctors to settle. Service clubs could take an interest. Interest free loans, guaranteed repurchase or the application of RIP funds to embellish housing could be effective. The same considerations might apply to other key workers like magistrates and school principals. Some investigation is called for.

v. TIME WITH THE FAMILY

Proper time off-call is the other main stress complained of by spouses in expressions like ""There is little time for family interaction with the father.. He is shared with the community." and "Possibly my one regret is that the children may remember their father as careworn, a little grumpy and always "at work"".[24]

Improvements depend on increases in both numbers of rural doctors and versatility in utilising the opportunities.

Since no other workers regularly operate such hours, there is an apparent need for research into both the clinical need for such hours and acceptable solutions.

C. COMMUNITY EXPECTATIONS.

Very little is published on the attitudes of rural communities to their health needs with the notable exception of Humphreys J,

I am unaware that governments locate and fund health facilities on any considered logical system based on population needs. Some ratios of Hospital beds to population pop up but their basis is unclear.

Mostly hospitals and other facilities are funded according to political pressure exerted by rural communities on their own behalf. Since this is a function of perceptions of need, one might expect that some studies might have covered the apparent requirements of rural communities. Literature search reveals almost nothing. (The outcry when a doctor is not replaced in a town speaks volumes but is not evidential of need).

I wonder if an area of public expenditure that swallows 8% of the Gross National Product might not deserve closed study!.

Of the critical areas of RECRUITMENT, TRAINING and RETENTION of Rural Doctors I have centred on the least well researched component, RETENTION. I have drawn attention to the relative dearth of information and research on the social family and professional causes that have been suspected or demonstrated to be responsible for rural doctors leaving the country, and I have suggested areas where studies appear most needed.

Since there is little value in running the taps into a bath with the plug out, it seems that endeavours should be made to fund research, particularly qualitative studies, on the factors that limit the stay of well trained country doctors in rural practice.

The Rural Doctors Association of Queensland is proud of its achievements in the last six years in forwarding the care of rural patients and the professional and social aspects of the lives of rural doctors.

My colleagues and I stand ready to assist and support research and programmes that cement those advances.

REFERENCES

1. PATKIN M. MJA1968 2 (5) 243 "The rural doctor problem."
2. WALPOLE R "Rural health" 1979 RACGP.
3. COLDITZ GA and ELLIOTT CJP "MJA 1978, v2,63-66."Queenslands rural practitioners."
4. DOUGLAS et al NCEPH Discussion Paper Number 5 1991
5. DICKINSON J 1991, Quoted in National Health Strategy, 1992 Background Paper No 11 Table 2., p 19.
6. US Dept of Health and Human Services 1984
7. RDAQ (Rural Doctors Association of Queensland.) Database1994 Personal Communication
8. KAMIEN M. (Chairman) " Report of the Ministerial Inquiry into the Recruitment and Retention of Country Doctors in Western Australia." 1987 Perth. West Australian Government
9. RABINOWITZ HK, New England J Med, 1993, 319:8,480. "Evaluation of a selective admissions policy to increase the number of family physicians in rural and underserved areas"
10. GILL D et al. "Country General Practice", Review of General medical practice in South Australia", Third report 1992 SA Health Commission 3.12 page 31ff
11. QUEENSLAND HEALTH 1993. "Workforce Characteristics of Medical practitioners in Queensland1991" pp 32,33 , Tables 25,26 27.
12. BIGGS StJ unpublished.
13. WISE A et al , "Vocational Training and Continuing Education for the Rural Medical Practitioner. QRPRG, Univ Queensland 1992, 5.14, p59.
14. ADHIKARI P, CALCINO G, DICKINSON J. Geographic mobility of general practitioners. 1993 . Presented at 2nd National Rural Health Conference, Armidale Feb 1993
15. PATHMAN 1992 quoted in (14)
16. HUMPHREYS J and WEINAND HC, Med J Australia 1991 154 ,773 "Health Care Preferences in a Country Town".
17. CAMERON B 1992 Paper at RDAQ Conference Atherton Jun1992
18. MERRIFIELD D 1993. Paper to RDAQ Conference Bundaberg Jun 1993
19. BAKER J. Personal Communication.
20. REID M and SOLOMON S NATIONAL HEALTH STRATEGY. Background Paper No 11, 1992 "Improving Australia's Rural health and Aged Care Services" p56ff
21. SONDERGELD S 1994. Personal Communication.
22. ONTARIO MEDICAL ASSOCIATION 1993. "Interim Agreement on Economic Arrangements" Schedule 3, 3A, 1.3. 1993.
23. WALTON V A et al, NZMed J 1990 103(892) 287 "Variety and views in general practice."
24. WISE A,CRAIG M ,NICHOLLS A. PGMEC RESEARCH GROUP "The Spouse of the rural medical practitioner. Qualitative Data. Dec 1991 Personal Communication
25. SKIPPER JK and EDWARDS JN "Social Science 1980 1.Winter.35-4. "Marital Decision Making or Not to be a Doctors Wife.
26. LORCH B and CRAWFORD LE, Internat J of Sociol of the Family 1983. 13,1,Spring 117 "Role Expectations, Performance and Satisfaction: a Comparison of Physicians' and Lawyers' Wives".
27. JOHNSON J, 1994 Queensland Country Life Jun94 "Medical Claim Insult to Bush".
28. HUMPHREYS JS and WEINAND HC , Community Health Studies, 1993 VolXIII,No3,258 "Health Status and Health care in Rural Australia,:a case study."
29. HUMPHREYS JS, Australian Geographical Studies, 1985, v23 no2 222. "A political economy approach to the allocation of health care resources: The case of remote areas of Queensland".

SELECTION	SELECTION	TRAINING
PRE UNIVERSITY	Pre-university	University
TRANSFER	School Careers staff contact	Affirmative selection students and partners from country
TRAINING	Mentorship and practice visits.	Student attachments
UNIVERSITY	Work experience	Mentorship
TRAINEE	Affirmative selection of rural pupils	Rural Clubs
RETENTION	Transfer	Trainee
PROFESSIONAL	Voluntary Provider Number control in areas of excess	Compulsory rural attachment for all trainees
FAMILY	Facilitated transfer to rural practice with training ==RIP	Mentorship
COMMUNITY ATTITUDE	Remote community support grants	Adequate access to RACGP Rural training scheme
	Reduction of marginal value positions in Rural Health Authorities	Increased Medicalisation of RHTUs
		Cadetship or Bonding

RETENTION

Professional

- CME training with Locum support (RHSET & RIP)
- Study Leave
- VMO fee for service in rural hospitals
- Facilitated entry to training schemes
- Appropriate Role Delineation of Rural Hospitals
- Guaranteed reentry to city practice.
- Fostering by city practices
- Satellite communications
- Doubling up Doctors
- Divisional projects.
- Hospital Staff training

RETENTION

Family

- Preview of rural location
- Jobs for partners
- Job Sharing
- Leave transport subsidies.
- Locum and relief provision
- Policy not to permit excessive working hours
- Education grants for children.
- Pastoral Care

Community Attitude

- Work experience
- Affirmative selection of rural pupils
- Transfer